

## Another first for Dr. Wendy Clay

Amy Chouinard

**T**he voice at the other end of the telephone sounds strong, clear and confident, the voice of someone who is comfortable with authority, laughs easily and is not about to be deterred by unwritten rules that keep women from attempting, much less doing, things. What she says is reminiscent of Loni Anderson's reply when asked if she's going to get fat from eating a box of chocolates: "I don't like fat so it just leaves me alone." Says Dr. Wendy Clay: "I have not personally experienced discrimination based on gender."

That statement is all the more remarkable because Clay, who will soon be promoted to the rank of brigadier-general, has been in the military 24 years and will become commandant of the National Defence Medical Centre (NDMC) in Ottawa, Canada's main military hospital, on July 31.

She will be the first woman to take on that job and one of only three who has made it to such a high rank. At present, 8148 women serve in the Canadian Forces; there is currently one female brigadier-general, who will retire as Clay and another woman move into the forces' upper echelons, to join roughly 120 males of general rank. Clay will become one of three officers of general rank in the Canadian Forces Medical Service.

Even without having met



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her, it is easy to imagine Clay, 46, at the controls of a Tutor jet trainer — she was the first woman to train to wings standard on that plane. "The reason I received training was my interest and experience in aviation medicine", she says. "Some of my male colleagues have been given the opportunity to do the same thing to get a better understanding of the stresses [facing] air crews."

A few years earlier she had become the first woman to receive training as a Canadian Forces flight surgeon and subsequently became base surgeon at Canadian Forces Base Moose Jaw, Sask., where she completed basic flight training.

"At the time ... they weren't training women pilots to fly operationally as they are now",

she recalls. "Subsequently, the government opened up various occupations." Those words offered an opportunity to ask the question I had been waiting for. What does she think of the recent move to place women in combat roles?

She pauses, but doesn't dodge the question. "I have to choose my words carefully. ... Let's just say I'm not aware of a large ground swell within the services for women to serve in the infantry in combat roles. For things like fighter aircraft, yes. Certainly there's no good reason that women can't fly any kind of aircraft.

"I'll put it this way: in the 24 years that I have been in the service, I have seen the opportunities for women expand radically. I was the first female doctor

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#### PRECAUTIONS.

**DOSAGE AND ADMINISTRATION:** CAPOTEN (captopril) should be taken one hour before meals. DOSAGE MUST BE INDIVIDUALIZED.

**Adults: Hypertension:** Initiation of therapy requires consideration of recent antihypertensive drug treatment, the extent of blood pressure elevation, salt restriction, and other clinical circumstances. If possible, discontinue the patient's previous antihypertensive drug regimen for one week before starting CAPOTEN. If this is impossible, especially in severe hypertension, the diuretic should be continued. The initial dose of CAPOTEN is 25 mg b.i.d. or t.i.d. If satisfactory reduction of blood pressure has not been achieved after one or two weeks, the dose may be increased to 50 mg b.i.d. or t.i.d. The dose of CAPOTEN in hypertension usually does not exceed 150 mg daily. Therefore, if the blood pressure has not been satisfactorily controlled after 1 to 2 weeks at this dose (and the patient is not already receiving a diuretic), a modest dose of a thiazide-type diuretic (e.g., hydrochlorothiazide, 25 mg daily) should be added. The diuretic dose may be increased at 1 to 2 week intervals until its highest usual antihypertensive dose is reached. If CAPOTEN is started in a patient already receiving a diuretic, CAPOTEN therapy should be initiated under close medical supervision (see WARNINGS and PRECAUTIONS (Drug Interactions) regarding hypotension), with dosage and titration of CAPOTEN as noted above. In severe hypertension, if further blood pressure reduction is required, the dose of CAPOTEN may be increased to 100 mg b.i.d. or t.i.d., and then, if necessary to 150 mg b.i.d. or t.i.d., while continuing the diuretic. The usual dose range is 25 to 150 mg b.i.d. or t.i.d. A maximum daily dose of 450 mg given in three equally divided doses should not be exceeded. For patients with accelerated or malignant hypertension, when temporary discontinuation of current antihypertensive therapy is not practical or desirable, or when prompt titration to more normotensive blood pressure levels is indicated, diuretic should be continued but other concurrent antihypertensive medication should be stopped and CAPOTEN dosage promptly initiated at 25 mg t.i.d., under close medical supervision. When necessitated by the patient's clinical condition, the daily dose of CAPOTEN may be increased every 24 hours under continuous medical supervision until a satisfactory blood pressure response is obtained or the maximum dose is reached. In this regimen, addition of a more potent diuretic, e.g. furosemide, may also be indicated. Beta-blockers may also be used in conjunction with CAPOTEN therapy (see PRECAUTIONS—Drug Interactions) but the effects of the two drugs are less than additive.

**Heart Failure:** Initiation of therapy requires consideration of recent diuretic therapy and the possibility of severe salt/volume depletion. In patients with either normal or low blood pressure, who have been vigorously treated with diuretics and who may be hyponatremic and/or hypovolemic, a starting dose of 6.25 or 12.5 mg t.i.d. may minimize the magnitude or duration of the hypotensive effect (see WARNINGS, [Hypotension]). For these patients, titration to the usual daily dosage can then occur within the next several days. For most patients the usual initial daily dosage is 25 mg t.i.d. After a dosage of 50 mg t.i.d. is reached, further increases in dosage should be delayed, where possible, for at least two weeks to determine if a satisfactory response occurs. Most patients studied have had a satisfactory clinical improvement at 50 or 100 mg t.i.d. A maximum daily dose of 450 mg of CAPOTEN should not be exceeded. CAPOTEN is to be used in conjunction with a diuretic and digitalis. Therapy must be initiated under very close medical supervision.

**Dosage Adjustment in Renal Impairment:** Because CAPOTEN is excreted primarily by the kidneys, excretion rates are reduced in patients with impaired renal function. These patients will take longer to reach steady-state captopril levels and will reach higher steady-state levels for a given daily dose than patients with normal renal function. Therefore, these patients may respond to smaller or less frequent doses. Accordingly, for patients with significant renal impairment, initial daily dosage of CAPOTEN should be reduced, and smaller increments utilized for titration, which should be quite slow (1 to 2 week intervals). After the desired therapeutic effect has been achieved, the dose should be slowly back-titrated to determine the minimal effective dose. When concomitant diuretic therapy is required, a loop diuretic (e.g., furosemide) rather than a thiazide diuretic, is preferred in patients with impaired renal function.

The following table which is based on theoretical considerations may be useful as a guide to minimize drug accumulation.

Creatinine Clearance (mL/min/1.73 m <sup>2</sup> )	Dosage Interval (Hours)
>75	8
75-35	12-24
34-20	24-48
19-8	48-72
7-5	72-108
	(3 to 4.5 days)

Captopril is removed by hemodialysis.

**AVAILABILITY:** CAPOTEN (captopril) is available as tablets containing: 25 mg of captopril—white, square, quadriseal scored on one side and imprinted CAPOTEN 25 on the other; 50 mg of captopril—white, oval, biconvex with a partial bisecting score and SQUIBB imprinted on one side and imprinted CAPOTEN 50 on the other; 100 mg of captopril—white, oval, biconvex with a partial bisecting score and SQUIBB imprinted on one side and imprinted CAPOTEN 100 on the other.

**Supplied:** 25 mg (Bottles of 100 and 1000)  
50 mg (Bottles of 100 and 500)  
100 mg (Bottles of 100).

**Storage:** Store at room temperature. Protect from moisture. Keep bottles tightly closed.

Product monograph available to physician upon request.

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to join under the medical officers' subsidization plan postwar; the majority of women were administrative clerks, nurses, dietitians—standard roles for women.

"In the mid-1970s, about two-thirds of the opportunities available to men opened up for women. The military is a traditional organization and change comes slowly. In the air force, a number of nontraditional roles such as mechanic, air-traffic controller, fire fighter, air-weapons technician had just opened up and people were still adjusting when the extra push came to open up all occupations to women. I think [the push was greater] outside the service than from within."

Like Clay, Commander Michael Shannon, a physician with the surgeon general's office in Ottawa, feels the military has made great strides: "Of the 302 physicians who are in the military, 55 [18%] are women, but of the 100-plus students in medical training [under the medical officer training plan], 46% are women. The numbers reflect the large movement of women generally into medicine, but also the change of attitude in the military. Now, all but a few combat positions are open to women."

Shannon, who is involved heavily with recruiting, says attitudes have changed towards women doctors, who must think not only of a medical career but of such issues as having children. "The military, in general, bends over backward to post husband-and-wife teams to the same spot; medical posting patterns are no exception. There are ample employment opportunities in our profession that are compatible with raising a family—we can accommodate almost anyone."

Shannon says the pay of military physicians has improved, as have other benefits such as continuing medical education and opportunities for post-graduate training. "When physicians want to take the first 5 years to raise their family, they are counselled on the kinds of postings to ask for and what to expect. That way, there are no

surprises and everyone is satisfied.

"As for the opportunities, well, anyone who knows Wendy Clay knows what is possible. In all likelihood she will be surgeon general someday. She has blazed the trail—a very impressive lady."

That she is. Born in Fort St. John, BC, and raised on Vancouver Island, she attended the University of British Columbia and enrolled in the Royal Canadian Navy. Her career has taken her as far away as peacekeeping service in the Middle East. "The peace treaty between Egypt and Israel was signed while I was there", she recalls. "I had a small medical organization that provided care to the Canadian contingent. We also looked after an Australian detachment, but if we had to hospitalize anyone in the theatre area, we had to refer to the Polish hospital. The differences in language and customs required a bit of liaison."

That experience, along with stints as director of medical assessment and training, of preventive medicine and, most recently, as command surgeon at Air Command Headquarters in Winnipeg, will prove valuable when she begins running the military's major referral centre in Ottawa. Open since 1961, the NDMC has 244 active beds. Most of its patients are from the immediate area, but military referrals also arrive from throughout Canada and abroad.

Clay has no immediate plans for changes at the hospital, but cites two major concerns of the military: the shortage of specialists and the inability to provide bilingual medical service at some times. "From the personal point of view, I understand there are about 50 chronic care beds being used for veterans and I'll be interested in the quality of care that might be given there."

Also, she says, she will devote her attention to NDMC's role in training medical assistants and nurses: "Being the largest military hospital, it serves as a clinical site for most people providing care in the forces." ■